

**WISCONSIN MEDICAID
PRIOR AUTHORIZATION / HOME HEALTH THERAPY ATTACHMENT (PA/HHTA)**

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Home Health Therapy Attachment (PA/HHTA) Completion Instructions (HCF 11044A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial) Recipient, Ima A.	2. Age — Recipient 67
3. Recipient Medicaid Identification Number 1234567890	

SECTION II — PROVIDER INFORMATION

4. Name and Credentials — Therapist I.M. Performing, P.T.
5. Therapist's Medicaid Provider Number 87654321
6. Telephone Number — Therapist (123) 456-7890
7. Name — Referring / Prescribing Physician I.M. Referring
8. Referring / Prescribing Physician's Medicaid Provider Number 12345678

SECTION III — DOCUMENTATION

9. Provide a Brief History Pertinent to the Service(s) Requested

Recipient admitted to hospital 04/15/05 after CVA with residual left hemiparesis. Discharged home on 05/01/05 at insistence of wife. Nursing home placement unacceptable to family. Prior to CVA, recipient was independent in ADL and active around the house, in the community, and with his grandchildren. Recipient did have low endurance and fatigue due to COPD.

10. Provide a Description of the Recipient's Diagnosis and Problems as They Pertain to the Need for the Therapy Services requested (Include the date of onset)

Recipient hospitalization complicated by pneumonia. Recipient has history of long standing COPD and arteriosclerosis. In 2000 he had mitral valve replacement and double bypass surgery. In 2001 he had L radical neck resection. Recipient alert, feels frightened, exhibits poor safety awareness, and unsteady when ambulating.

SECTION III — DOCUMENTATION (Continued)

11. State Therapy History (Indicate type / date / location for all types of therapy)

Service Area	Location	Date	Problem Treated
Physical Therapy	Hospital	04/18/05 to 4/30/05	Hemiplegia — therapeutic exercise, ROM, balance activities, ADL
	Home	05/01/05 to present	
Occupational Therapy	Hospital	04/18/05 to 4/30/05	Hemiplegia — motor skills
	Home	05/01/05 to present	
Speech and Language Pathology	Hospital	04/18/05 to 4/30/05	Dysphagia
	Home	05/01/05 to present	

12. Indicate the Date of Initial Evaluation (Supply dates / tests used / results of additional evaluations)

ROM, MMT, ADL, Gait — 5/1/05. AAROM WNL all extremities, except as follows: R shoulder, Flex 0-130, ABD 0-120, IR 0-50; L shoulder flex 120, ABD 0-110, IR 0-30, BILAT Knees — 5 extension, transfers — moderate assist of one. Recipient has excessive trunk extension, ground weight bearing R LE, minimal weight bearing on LLE. Recipient requires min-moderate assist to complete all bed mobility. Moderate assist to ambulate for 100 feet times 3 with wheeled walker. Recipient becomes short of breath, has poor balance and excessive trunk extension.

13. Describe Progress in Measurable / Functional Terms Since Treatment Was Initiated or Last Authorized

Recipient remains as above. Recipient has active movements in all L LE joints. Movements independent, but with mild extensor tone in LLE and mild flexor tone in LUE. Supervision to minimal assist to complete pivot transfers. Recipient demonstrates proper technique and weight shifting from sit to stand: but continues to have excessive trunk extension from stand to sit. Recipient independent in bed mobility with tactile cueing. Good unsupported, unchallenged sitting balance. Recipient able to ambulate 200 feet with wheeled walker and supervision of one for occasional loss of balance backwards. Gait does exhibit decreased weight shift to L, minimal flexion in L LE decreased step length on R, decreased floor clearance with increased retraction L. hip.

14. Attach a Plan of Care Indicating Specific, Measurable Goals and Procedures to Meet Those Goals

See attached plan of care.

15. Describe Rehabilitation Potential

Excellent. Recipient has made excellent progress in the past month with 3X week therapy. He is well motivated and cooperates with therapy program. Anticipate recipient will be independent in ADL and gait if no complications occur and PT continues with home health aid carry through.

16. SIGNATURE — Requesting Provider <i>IM Performing P.T.</i>	17. Date Signed 06/06/05
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